Culture Referral Form

Label

Patient Information:

Name: _____

DOB: _____

Specimen Information:

Specimen Type: _____

Source: _____

Testing Requested:

☐ ID Only ☐ MICs only ☐ ID & MICs

Growth Type:

☐ Aerobic ☐ Anaerobic ☐ Choc only ☐ Other: _____

Gram Stain Information:

☐ Positive ☐ Negative ☐ Variable

☐ Coccus ☐ Bacillus ☐ Diplococcus ☐Coccobacillus

Additional Identification Information:

_____

_____

_____

_____

_____

Suspected ID:

_____

Contact Information for Questions and/or follow:

_____

****If Alomere Health's Micro department is unable to ID and/or get MICs, would you like for additional testing to be done at Mayo Laboratories?**

☐ Yes ☐ No